Community services for people affected by violence: An exploration and categorisation

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Articles

Community Services for People Affected by Violence

An Exploration and Categorization

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Abstract

- *Summary*: In this article we explore the extent of services offered by voluntary community groups in Northern Ireland 10 years after the ceasefires.
- *Findings*: People who have been exposed to community violence and related traumatic life-events often require help in coping with the effects of these experiences. While many people rely on family and friends for support and few require in-depth professional social work and therapeutic help, there is an increasing reliance on community services. Community services now offer a range of services from informal self-help groups, befriending, complementary therapies, respite, narrative work, to psychological therapy.
- *Application*: We explore how these services are organized, who is using them, how they can be categorized, and finally we suggest minimum standards for good practice.

Keywords community services people affected by violence post-traumatic stress

Introduction

The experience of trauma or violence can seriously impact people's physical and mental well-being. Following a traumatic event, up to 33 to 50 percent of the victims fall within the categories of Post-traumatic Stress Disorder (PTSD; *Diagnostic and Statistical Manual of Mental Disorders*, DSM-IV, 1994) in the short term. However, while there are individual as well as cultural differences, in the long term, PTSD is diagnosed in only eight percent of cases (Pfefferbaum, 1997).

While some people may turn to prescribed antidepressants or other psychopharmaca in the short term (Harvard Program in Refugee Trauma, HPRT,

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2005), most people do not require specific psychological or psychiatric services (Sprang, 2000). In fact, in a recent poll by the Royal Institution, post-trauma counselling was considered one of the worst ideas on the mind (Jarrett, 2006). In addition, a Cochrane review has shown that there is 'no current evidence that psychological debriefing is a useful treatment for the prevention of post-traumatic stress disorder after traumatic incidents'. The review authors went as far as to recommend that, 'compulsory debriefing of victims of trauma should cease' (Rose et al., 2001). Of course there is a difference between post-trauma counselling and one session debriefing; however, it seems that for most trauma victims practical help and the support from family members and friends are the most likely forms of effective help (Jones, 2006). However, in cases where those who are expected to offer support have been traumatized themselves, they may not be able to offer sufficient support (Dillenburger, 1992a). In such situations, community support networks can fill the gap (LeDoux and Gorman, 2001).

Figure 1 shows a hierarchy of service needs in which informal networks are utilized initially by the majority of people and, as the intensity and professionalism of services increases, the number of service users requiring the service decreases. It is important for social workers to comprehend the place and complex network of community service provision for people affected by violence, not only because they can be a source of referrals but also because

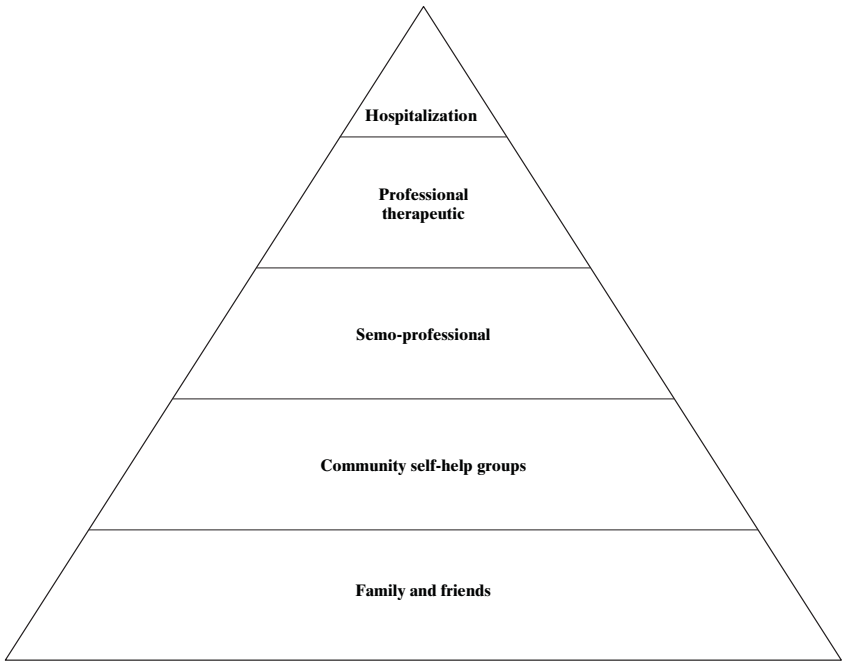


Figure 1 **Hierarchy of service needs**

they can offer a resource to which social workers can refer service users to. Of course, some community groups employ social workers as part of their team.

Presently however, little is known of the services offered by community groups for people affected by violence and trauma. In fact, it has been suggested that while these groups may be able to help their members experience less psychological distress or depression and improve social functioning (Caserta and Lund, 1993), it is possible that they can also result in unhelpful or even negative effects, such as pressure to conform to group norms, embarrassment, stress related to group obligations, interdisciplinary tensions, members' feeling overwhelmed and less adequate, and learning ineffective or inappropriate social skills. Leaders can suffer burnout, and power struggles can result in tension (Galinsky and Schopler, 1994).

In this article we explore community and voluntary group services for people affected by violence in Northern Ireland. We conducted a detailed survey of 26 victims and survivors groups which have developed over the past 10–30 years. First, we outline briefly the background to community violence in Northern Ireland and identify service users of community services. Then we detail service provision, and address questions such as, how can we categorize services, how the groups work, who works for them, and who they work for. Finally, we make recommendations for minimum standards of good care in community services for victims of trauma.

Background

In Northern Ireland persistent community violence, commonly known as the Troubles, has ranged since 1969. Most of the one-and-a-half million people living in Northern Ireland have been affected one way or another, either by having lost a close relative (over 3600 people were killed as a direct result of the Troubles), being injured, witnessing an explosion or shooting, or being intimidated. Many have experienced more than one of these events (Bloomfield, 1998).

In the early years, little was known about individuals who were most severely affected by violence (Dillenburger, 1992b) and little help was available (Darby and Williamson, 1978). After the 1994/5 ceasefires when the death toll decreased and paramilitary-style punishment beatings, sectarian attacks, and inter-paramilitary feuding increased (Healey, 2004), more attention was paid to the impact of community violence (Kapur and Campbell, 2004; McConnell et al., 2002; Smyth, 1999 **[AQ: not in refs list, please supply]**). Victims Commissioner Bloomfield (1998) made recommendations on how best to remember the victims and the Office of the First Minister and Deputy Minister (OFMDFM) instituted a Victims' Unit (VU). Trauma Advisory Panels (TAPs) were established in collaboration with the four regional Health and Social Services Boards and, since 1998, over £44 million of central government and European monies have been spent on victims and survivors (McDougall, 2006).

The intense focus on victims' issues, coupled with an injection of resources, led to a rapid growth in the voluntary and community services sector. In the main, people who had been affected by violence themselves set up self-help groups and received governmental support.

For many people these groups represent a key point of contact. They provide opportunities for people to come together for mutual support; some provide a range of services themselves and they can also provide a channel through which individuals may access services provided by the statutory sector and those provided by other voluntary or community groups (The Victims Unit, 2005).

Today, voluntary groups are largely considered as main service providers for people affected by community violence (Deloitte & Touche, 2001). However, service provision remains largely divided along sectarian lines, with most groups serving single identity communities. Only some groups service across the entire bi-cultural community of Northern Ireland (Dillenburger et al., 2005).

Of course, there are difficulties with community service provision. In a recent interim report, the new victims commissioner Bertha McDougall (2006) confirmed that:

> while there were many pockets of good practice, they were not consistent across all areas of Northern Ireland and not accessible to everyone . . . Lack of co-ordination had led to confusion, duplication of funding, gaps in funding, over-administration and an incomplete picture of provision.

In order to provide a more complete picture of provision more information is necessary, especially regarding categorization and level of services, membership, or staffing. Kelly and Smyth (1999) found that service provision was limited and patchy; 22 percent of the groups they surveyed offered a wide range of services to bereaved and injured of the Troubles, but only 16 percent offered structured counselling, therapeutic services, or emotional support. Detailed information about services and service users was not available.

Who Needs Community Support Services?

Most people experienced some kind of trauma or bereavement at some point in their lives and there is a difference between the typical or expected process of coping and pathological or complicated grief reactions (O'Reilly and Stevenson, 2003; Stroebe and Stroebe, 1987). A number of vulnerability and protective factors seem to be important (Dillenburger and Keenan, 2005). The mode of death or trauma plays an important role in the outcome and it is recognized that survivors of violence are at greater risk of poor bereavement outcome; the individual circumstance at the time of trauma as well as social factors play important roles in coping; and of course, cultural factors are also important (Figure 2). Clearly therefore, each person, family, and community experiences trauma and violence differently and the effects on their lives and health vary (Dillenburger et al., 2006).

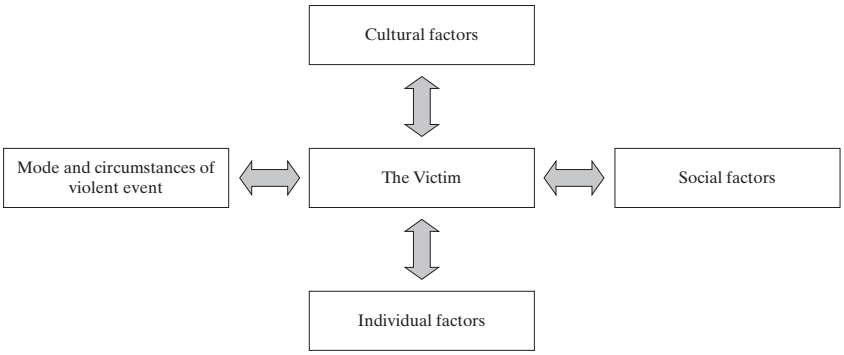


Figure 2 **Risk and protective factors for coping with violence**

Figure 2 illustrates the interdependence and the multi-directionality of the coping process, between the individual who has experienced violence or trauma and vulnerability and protective factors that influence recovery, notably, the circumstances of the event, individual, social, and cultural factors (cf. Dillenburger and Keenan, 2005).

What are Community Services?

Depending on risk and protective factors, individuals obviously need different types of support. Maslow's (1954) hierarchy of needs offers a good general guide. Initially, during the violent event, obviously the person is concerned about physiological needs and physical safety. However, concerns about emotional safety and belonging soon follow. In the recovery phase, the meaning of the experience needs to be considered and new behavioural repertoires need to be established (Moynahan, 2001). While usually, most of the early needs are provided for by family and friends, other support systems may become necessary at a later stage and in the longer term.

Community-based Services

There is ample evidence that appropriate social support is a key element when coping with traumatic experiences and that most individuals do not require specialized mental health interventions in order to cope with traumatic experiences. In Northern Ireland, community-based services offer self-help groups, befriending, respite care, youth work and narrative work and are considered to be less stigmatizing and more empowering than statutory services (Smyth, 2001). Nonetheless, facilitators and staff who offer community-based services need to be well trained and supervised. Osterweis et al. (1984) suggested that attentive listening, continuing long-term relationships, empathy, personal coping strategies, observational skills, and appropriate referrals are important key elements for community-based services.

Self-help groups can be a valuable adjunct to psychotherapy or, as stand-alone community based service, they offer a rich source of social support, information, and general sharing of common problems and concerns. Burnell and Burnell (1986) point out that while relatives and friends can offer temporary emotional support, mutual support groups provide a longer lasting resource. In fact, it has been argued consistently that most individuals do not require specialized mental health interventions in order to adapt to traumatic experiences, but need community and family support and contact networks.

Osterweis et al.'s (1984) thought that mutual support/self-help groups can offer person-to-person based identification and reciprocity, access to a body of specialized information, an opportunity to share coping techniques, based on realistic expectations for optimal functioning, and an increased sense of personal worth, obtained by focusing on how similar members are to others confronting the same situation. A particular task of these groups is to offer reinforcement for positive change, to ensure maintenance of change through feedback on performance, to provide advocacy and social change, and offer an opportunity for education, as well as help for the helpers.

There is little research on evidence of effectiveness of *befriending* as an intervention for traumatized individuals (Dillenburger et al., 2006). While there are no clear definitions, some research has found that befriending by volunteers (especially, if trained and supervised) may be an effective way of combating problems of loneliness and isolation (Bradshaw and Haddock, 1998; Harris et al., 1999; Heslop, 2005; Taggart et al., 2000).

Narrative work is frequently used in community-based services. It can include different formats such as oral, auditory, visual, or written (Chaitin, 2003); for example, the creation of a book, a digital archive, a journal, or poetry. Bolton (2004) argued, when the certainties of life are stripped away by death, dying, and bereavement writing can enable the bereaved to question and begin to find some sort of a route to answering. Freedman and Combs (1996) agree and describe the work of narrative therapists as:

> working with people to bring forth and thicken stories that do not support or sustain problems. As people begin to inhabit and live out the alternative stories, the results are beyond solving problems. Within the new stories, people live out new self images, new possibilities for relationships and new futures. (p. 16)

Psychology-based Services

Psychology-based services include professional counselling, group therapy, or psychotherapy. These kinds of psychology-based services are generally carried out by professionally and accredited therapists who work from a specific and clear psychological, theoretical, and/or methodological basis.

Counselling has been defined as:

> a systematic process, which gives individuals an opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well-being.

> Counselling may be concerned with addressing and resolving specific problems, making decisions, coping with crises, working through conflict, or improving relationships with others. (NHS Centre for Reviews and Dissemination, 2001)

Rather than focusing on psychopathology, counselling emphasizes individual resources and focuses on a reflective process (Department of Health, 2001).

Group therapy is a setting where trauma survivors are able to share experiences within the safety, cohesion, and empathy provided by other survivors, telling their story to a group and thereby potentially facing the grief, anxiety, and guilt related to trauma (National Centre for PTSD, 2005).

Psychotherapy has been defined as:

> all formal and systematic psychological therapies, or talking treatments, which are offered by psychotherapeutically trained practitioners. Cognitive behavioural, psychoanalytic, psychodynamic, humanistic-experiential, interpersonal, and cognitive-analytic would all be examples. (Parry, 2003: 57)

Psychotherapy encompasses a diverse range of activity, but all psychotherapies have in common a systematic intervention, based on explicit psychological principles, to improve health, well-being or self-efficacy (Cape and Parry, 2003).

Philosophy-based services

Complementary therapies, such as aromatherapy, reiki, acupuncture, massages, shiatsu, and reflexology are usually based on eastern philosophies and comprise many different disciplines and a wide spectrum of practices. Conventional medicine traditionally aims at diagnosing illness and treating, curing, or alleviating symptoms. Many complementary disciplines aim not only to relieve symptoms and restore wellness but also to help individuals in a process of self-healing within a holistic view of health (Mason et al., 2002).

Recent surveys have suggested that around one in five people in the UK have tried at least one form of complementary therapy and that one in 10 General Practitioners are actively involved in complementary and alternative medicine. Women use complementary therapies more than men and favour treatments such as aromatherapy and massage. Men are most likely to turn to complementary therapies for specific physical problems such as sports injuries or back pain (BBC, 2005).

Education-based services

Many of the voluntary groups help their members with urgent practical needs such as dealing with financial and legal matters in the form of *advice and information* or through referral to outside agencies and organizations. This type of service can aid service users in dealing with immediate problems and provide them with specific information about available services.

Indirect educational services such as computer classes, literacy and numeracy, and specific training can play also an important role for people

affected by violence as they offer the opportunity of exploring opportunities for empowerment.

While many community groups state that they are offering a range of the above services (Kelly and Smyth, 1999), little is known about what it is exactly that these groups do and who is using the services. Therefore, the questions addressed in this article are

- What services do community groups offer?
- Who is using these services?
- How are these services categorized, structured, and delivered?
- What are minimal standards of good practice for these services?

Method

Participants

The target population for this study were all voluntary community services groups that are core funded through the Strategic Implementation Fund by the Victims Unit (VU) in Northern Ireland. A total of 43 groups were identified. Twenty-six of these groups took part in the study. The groups were located across all of Northern Ireland, although a concentration of groups was located in the Greater Belfast area. The groups were all working with people who had been affected by the Troubles and offering a wide range of services, including community, psychologically, philosophically, and educationally based services. The size of the groups varied from 100 to 2000 members and some groups were single identity while others were cross-community groups.

Research Tool

The Community Services Questionnaire (CSQ) was designed for this study. The first part of the questionnaire requested general information about each of the groups, such as when and how they were founded, and their aims and objectives. In Part 2, information about the number, demographics, and needs service users of each group was collected. Questions in Parts 1 and 2 were similar to those posed by Coll (2006), Deloitte & Touche (2001), Dillenburger (1992b), Kelly and Smyth (1999) and Manktelow (2007). In Part 3, information regarding the range of intervention methods and services was gathered in some considerable detail, for example, questions related to staff training and supervision, referral process, length of service provision, etc.

Procedure

There are many ethical considerations that need to be taken into account when researching vulnerable populations, such as people affected by violence. For example, researchers must ensure not to 'open old wounds', make sure that research question do not cause distress, guarantee to adhere strictly to

confidentiality, and assure participants that services are not affected by participation, or refusal to participate, in a study (Dillenburger and Fargas, in press).

To make sure that all ethical considerations were taken account of fully, the Office for Research Ethics Committees (OREC NI) scrutinized the proposal in great depth (including personal interview of principal investigator) and gave ethical approval for the study. An explanatory letter was sent to the chairperson of all four Trauma Advisory Panels (TAPs). Participant information and signed consent sheets were used according to OREC guidelines. Regular research steering group meetings were held with the Victims' Unit (OFMDFM) to report progress and discuss details or concerns throughout the research.

A pilot study was carried out with five voluntary groups (approximately 10 percent of population). Following a phone conversation with the chairpersons to gain agreement for participation, the CSQ was sent by surface mail or email, depending on preference. Questionnaires were returned within one to two weeks. Follow-up telephone calls were made where questionnaires had not been returned on time. Only very minor changes were made for the final version of the CSQ, for example, order of question rearranged or typos corrected.

In the main study, the CSQ, a participant information letter and consent sheet, as well as a stamped addressed return-envelope, were sent to the remaining 38 core-funded groups. Follow-up telephone calls were made where questionnaires had not been returned within two weeks. Repeat CSQ were sent where this was requested. Twenty-six questionnaires were returned.

Results

Description of Groups

The 26 groups that took part in the study were formed between the years 1971 and 2002. Most of the groups were formed in 1998 onwards (Figure 3).

The majority of the groups were working only with people affected by the Troubles (n = 16), but some of the groups were helping other people as well (n = 10). The groups employed between one and 37s s s staff, although many had between three and six (n = 14) and some of them did not employ any paid staff and were staffed by voluntary workers (n = 3).

Service Users

In total, an estimated 6000 or 7000 people used the services of the respondent groups. Most groups served between 100 and 1000 service users (n = 15), although some served fewer than 100 (n = 9), and one group served as many as 2000 plus. Over the years, the groups served an estimated 15,000 service users. The majority of service users were females although the vast majority of the groups worked with men as well (n = 23). Most groups worked with adults aged between 18 and 64, although some worked also with children or young people.

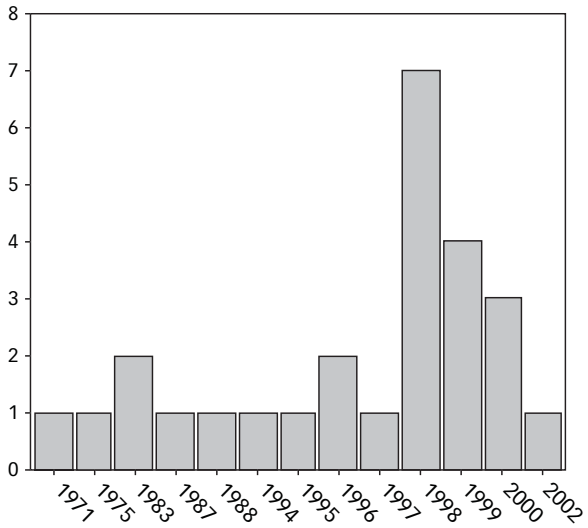


Figure 3 **Year of formation groups**

Categorization of Services

The services fell into four categories. While most of the groups used *community-based* (n = 22) and *education-based* approaches (n = 24), *psychology-based* services (n = 19), and *philosophy-based* approaches (n = 18) were also very popular amongst some of the groups.

Community-based Services Community-based services were offered in the following five sub-categories:

1. Befriending
2. Support/self-help groups
3. Respite care/time-out
4. Youth work, and
5. Narrative work (storytelling).

Befriending. Befriending was one of the most frequently offered services. Of the 26 groups who took part in the study, 17 provided befriending. Approximately, between 10 and 500 service users used befriending in each group. The groups had between one and 12 befrienders who offered their services between one and 32 hours per week, although depending on the needs of service users, many groups did not offer a fixed number of hours (n = 7). Even though training levels varied, most of the befrienders had some sort of qualifications (n = 13) and some level of supervision (n = 12). Befriending usually consisted of home visits or group meetings/activities in drop-in centres. Often, befrienders helped members to fill out forms or other practicalities.

Support and self-help. Seventeen of the community groups we surveyed offered support and self-help. The number of service users ranged from six to 700 people. The number of people in each support group varied (between three and 35), although most group meetings included four to 12 service users with similar experiences of violence (n = 14). The frequency with which they met varied from twice a week to once a month, although most met at least once a week (n = 9). One or two trained facilitators were available for the majority of the support groups (n = 11).

Respite care/time-out. Respite care/time-out was offered by 15 of the groups surveyed. Between 20 and 300 people availed of this service in each group and the main activities were day trips, holidays, or short breaks, although in one case time-out consisted of 'residentials' and personal development courses.

Youth work. Youth work was organized by 11 of the groups. Between 15 and 150 people were using this service. It was facilitated by between two and 20 facilitators, although some of the facilitators were brought in from other service providers. Most of the facilitators were trained (n = 7). They offered a great variety of group activities such as sports, training events, trips away, summer schemes, drama, music, and computer courses, and social events, such as parties or discos.

Narrative work. Twelve groups offered narrative work, that is, allowing service users to tell their stories. Narrative or storytelling was carried out in group meetings (n = 4), in individual meetings (n = 3), or both (n = 3). The duration and frequency of the meetings was not consistent. In one of the groups, it was offered for six months, in another for one year, in others it depended on the needs of the individual service users. One group created a book of memories and another group created a digital archive. In most of the groups (n = 8) narrative work was facilitated by trained staff and the number of users ranged from five to 400.

Psychology-based Services Psychology-based services were offered in the following three sub-categories:

1. Psychotherapy
2. Counselling
3. Group therapy

Psychotherapy. Psychotherapy was offered by only three of the groups. In one of these, four people used the service on a referral basis (using therapists outside the group). Another group had three trained psychotherapists, who were working with 130 people. The other group did not state how many psychotherapists had, but they were all trained. The approach used in one of the groups was cognitive-behavioural therapy (CBT; Harvey et al., 2003), including Eye Movement Desensitization Reprocessing (EMDR; Shapiro, 2001). The other two groups offered a combination of different approaches that they did not specify under psychotherapy. The service did not involve a specified number of

sessions, and rather the number of sessions depended on the needs of each individual. The longest period of therapy for one person had been 18–24 sessions, and in another group, one year, while the shortest had been two to three sessions.

Counselling. Counselling was used by 16 of the groups. Some groups brought in trained and accredited counsellors on a sessional basis or referred their service users to counsellors outside the group (n = 4). In each of these group, between two and 150 people availed of this service and it was offered by one to four trained counsellors per groups, although one of the groups had eight and another group used up to 12 counsellors at any one time. The number of sessions depended on the needs of the individual in 15 of the groups. The longest period of counselling offered was two years in one case and in another case 30 sessions were offered. The shortest time was a single counselling session. The most popular approaches were client-centred Rogerian (n = 8), cognitive-behavioural (n = 8), problem-solving (n = 7), humanistic (n = 4), and eclectic (n = 3). Two of the groups were using psychodynamic approaches. Other approaches used were Human Givens, and transactional.

Group therapy. Seven groups reported offering group therapy, although, in some cases it was not clear what exactly was meant by this. In most cases, the activities that were labelled group therapy resembled those of support groups rather than specific therapeutic interventions. Between 12 and 250 people were using this service. Each group consisted of between two and 18 service users and had between one to three facilitators, who were trained in five of the groups. They met from six times per year to as frequently as more than once a week. Five organizations based their therapy groups around themes, such as conflict, anger, dealing with trauma, or personal empowerment.

Philosophy-based Services Philosophy based services offered by the groups in this study included primarily services based on eastern philosophies, that is, complementary therapies.

Eighteen groups offered a range of *complementary therapy* services, including reflexology (n = 18), massage (n = 13), aromatherapy (n = 12), reiki (n = 10), art therapy (n = 8), music therapy (n = 5), drama therapy (n = 4), Indian head massage (n = 3), yoga (n = 3), and acupuncture (n = 2). Other therapies offered were the Bowen technique and homeopathy. The number of service users per each group ranged from seven to more than 100 and the number of trained therapists ranged from one to 19. Therapists were usually brought in rather than in permanent employ of the groups. The number of sessions offered varied greatly among the groups and in the vast majority of cases this depended on funding cycle.

Education-based Services Education-based services were offered by most of voluntary groups in the following two sub-categories:

1. Advice and information
2. Indirect services

Advice and information. In total, 22 groups provided advice and information. The vast majority of service users in each group used this service but the numbers varied from two to more than 1000 people. The kind of advice/information given most frequently were financial assistance (n = 19), help with practical needs (n = 17), and advice regarding legal matters (n = 10). Other advice or information was related to benefits, grants, and welfare advice (n = 10), housing (n = 3), careers guidance (n = 2), and health and dietary advice (n = 2). Advice/information was usually provided in a drop-in facility (n = 18), as written information in leaflets, newsletters (n = 15), by appointment (n = 13), or through a telephone helpline (n = 9).

Indirect services. Indirect services were provided by most of groups (n = 18). The number of users ranged from four to more than 400. The indirect services most often offered were small grants for members (n = 14), training and supervision for staff members (n = 14), research (n = 13), working with new or developing groups (n = 11), lobbying (n=9), advocacy (n = 8), and giving advice to community development and capacity building (n = 8). Many groups also provided computer courses and other kinds of courses (e.g. music, drama) and workshops (e.g. picture framing) (n = 13). One of the groups was exclusively dedicated to seeking financial support for families who had to be evacuated from their homes and farms as a consequence of sectarian intimidation.

Figure 4 summarizes the services offered by community groups. Undoubtedly, community- and education-based services are the mainstay of these groups; however, professional/therapeutic philosophy- and psychology-based services are also offered.

Figure 5 summarizes the numbers of groups offering each of the services. Clearly, service users availed of community- and education-based services more frequently than psychology- or philosophy-based services with advice and information the most frequently used service, followed by befriending, self-help, respite, and indirect services.

Selection of Service Users

Some of the groups had selection or eligibility criteria for service users who requested services (n = 19), such as belonging to a certain organization (usually along sectarian lines), being from a certain geographical area, or having been affected by a particular traumatic incident (e.g. the Omagh bomb in 1998). A small number of groups referred to certain criteria (n = 5), such as being an *innocent* victim of the Troubles, being a victim of *terrorists*, not being an ex-prisoner, and not having any connection to paramilitaries. Eleven of the groups had selection criteria for the allocation of services and individual service users were assessed prior to service allocation. Eleven of the groups planned to widen their appeal to include areas/groups of people that they were not presently

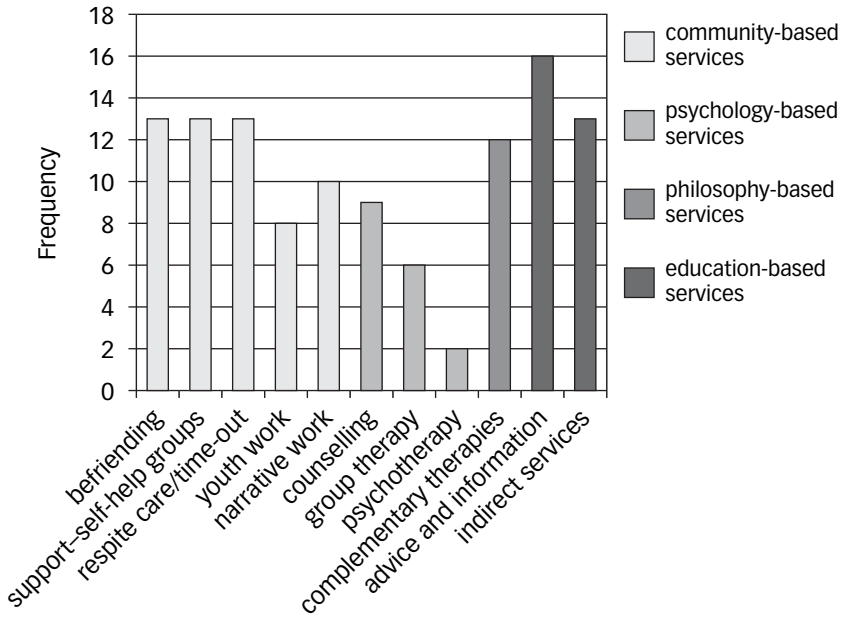


Figure 4 **Number of groups offering each service**

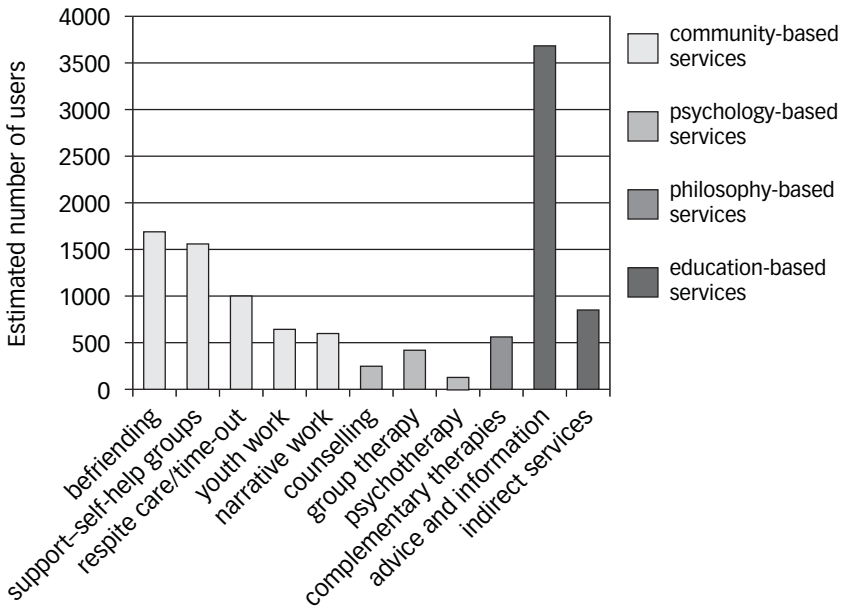


Figure 5 **Estimated number of people using each service**

involved with, such as young people (n = 3), people from rural or isolated areas (n = 1), the travelling community (n = 1), ethnic minorities intimidated by paramilitaries (n = 1), or cross-community (n = 1). Most of the groups conducted some sort of evaluation of services (n = 21), either by informal feedback (n = 17) or by formal feedback, such as interviews or questionnaires (n = 17). Eight of the groups had written a report about their evaluation.

Figure 6 gives a diagrammatic representation of service offered by community groups. In the left column the broad categories developed in this article is used. In the middle column a more detailed categorization of services is developed in each of the broad categories. In the right hand column a comprehensive fine-grained categorization of these services is delineated from the data presented in this article. This systematic categorization allows the delineation of minimum standards of service delivery. Most of the groups in our study meet these minimum standards, although some of the terms, for example, training and supervision are open to interpretation. Currently, no data are available on details regarding the actual training or supervision of staff. Clearly, more detailed information is required from future studies.

Discussion

Community and voluntary groups that aim to help victims of trauma are important in political, legal, as well as therapeutic terms and are becoming more and more influential in relation to education, empowerment, and advocacy (Mohr, 2004). In this article we reported a detailed study of community services offered to people who have experienced the trauma of the Troubles in Northern Ireland.

In Northern Ireland, voluntary victims groups have increased in number since the 1994 ceasefire and become a viable alternative to other forms of treatment and help for people who have experienced trauma. These groups are generally formed to offer service users help to deal with the effects of traumatic experiences. Generally speaking, most of these groups aim to reduce the isolation of their members, empowering them to help themselves, and improve coping with the consequences of the Troubles.

We found that these services were varied in quantity and quality. For example, some of the community groups were not very clear about the difference between group therapy and support groups or befriending and in some groups the range of services offered seem to be more related to available funding rather than an analysis of the needs of service users.

Many groups felt that the most appropriate way of providing services to victims was through groups that were victim-led (Clio Evaluation Consortium, 2002), in which, by and large, members shared similar experiences and concerns. They felt that these groups understood them better than professionally led agencies. In general, service users seemed to prefer social support provided in form of befriending and support groups as well as advice and information. It

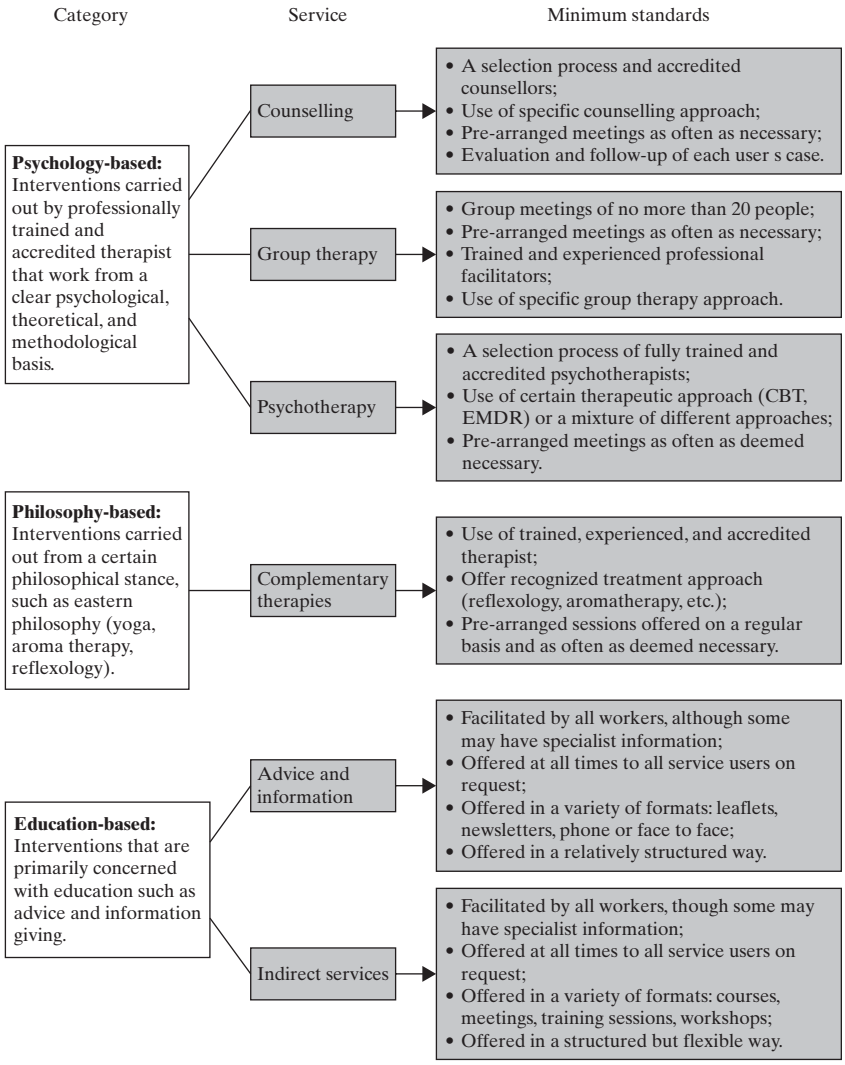
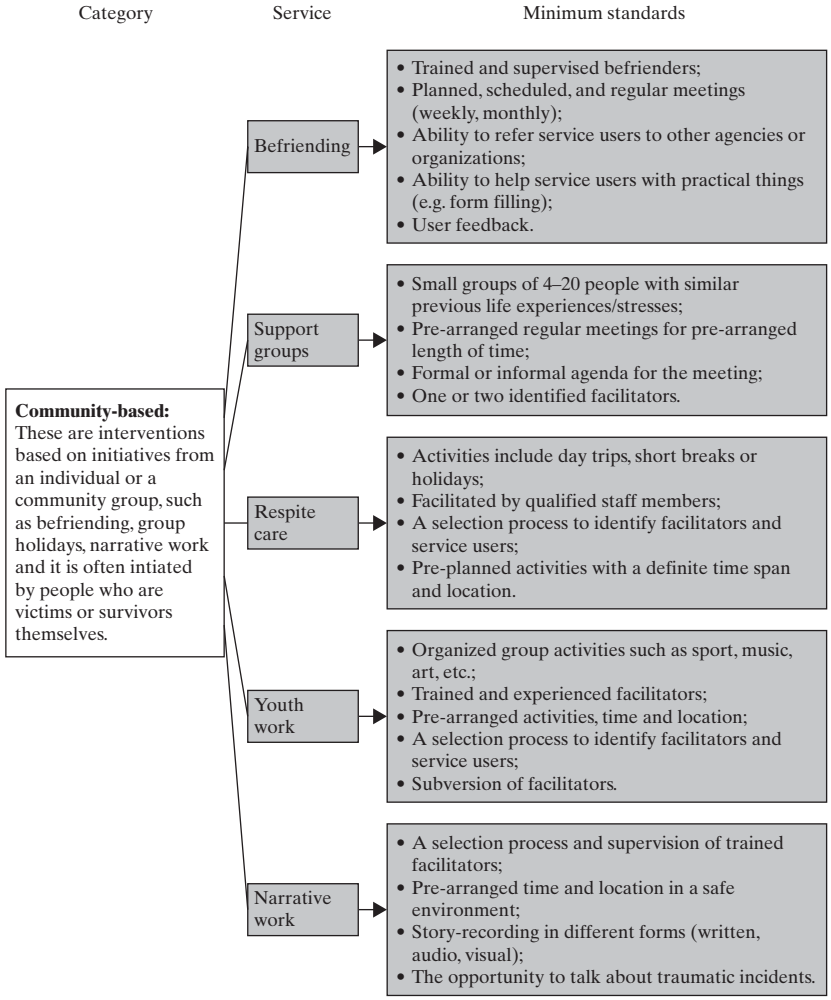


Figure 6 **Categorization of services and minimum standards**

may be better, as Wesseley (2003) recommends, to 'concentrate on delivering effective treatments to the smaller number of people who really need them, and not on the larger number of people who don't'. The choice of services seemed to be related to risk and protective factors such as the severity of the experience of violence, social, and community backgrounds.



Recommendations

A number of recommendations follow on from this study:

- A comprehensive data bank of community groups should be established with exact details of services offered. This data bank requires continuous updating as new groups are generated and existing groups close or change focus frequently.

- Social workers must be fully apprised of services offered by community groups. Social workers should be encouraged to utilize the services of these groups by referring service users, when appropriate.
- There is an urgent need to assess the effectiveness of services provided by community groups (Dillenburger et al., 2005).
- Resource allocation needs to be assessed.
- A comprehensive guide to minimum standards should be established based on the findings reported here.

While the recommendations above are not a call for professionalization of voluntary services, it is important that minimum guidelines for good practice as well as effectiveness measures are available in order to offer a level of protection of service users while not taking away from the spontaneity and self-help ethos of these groups.

Finally, social workers must take cognizance of the plethora of services provided by community self-help groups. The picture is by no means uniform. When referring to these services, account should be taken of quality control, probably best achieved through personal acquaintance and effectiveness data of the actual services provided. Having said this, community self-help groups have an important part to play in supporting people affected by violence in the area between the personal and the professional.

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References

BBC (2005) 'Complementary Medicine', available online at: [http://www.bbc.co.uk/health/healthy_living/complementary_medicine/basics_whatisit.shtml], accessed 15 November 2005.

Bloomfield, K. (1998) *'We Will Remember Them': Report of the Northern Ireland Victims Commissioner*. Belfast: The Stationery Office Northern Ireland.

Bolton, G. (2004) 'Opening the Word Hoard. Editorial: Death, Dying, and Bereavement', *Journal of Medical Ethics: Medical Humanities* 30: 49–52

Bradshaw, T. and Haddock, G. (1998) 'Is Befriending by Trained Volunteers of Value to People Suffering from Long-term Mental Illness?', *Journal of Advanced Nursing* 27: 713–20.

Burnell, G.M. and Burnell, A.L. (1986) 'The Compassionate Friends: A Support Group for Bereaved Parents', *The Journal of Family Practice* 22: 295–6.

Cape, J. and Parry, G. (2003) 'Clinical Practice Guidelines Developments in Evidence-based Psychotherapy', in N. Rowland and S. Goss (eds) *Evidence-based Counselling and Psychological Therapies: Research and Applications*, **[AQ: pp nos?]**. London: Routledge.

Caserta, M.S. and Lund, D.A. (1993) 'Intrapersonal Resources and the effectiveness of Self-help Groups for Bereaved Older Adults', *The Gerentologist* 6: 269–99.

Chaitin, J. (2003) 'Narratives and Storytelling', in G. Burgess and H. Burgess (eds)

Beyond Intractability, **[AQ: pp nos?]**. Boulder: Conflict Research Consortium. University of Colorado.

Clio Evaluation Consortium (2002) *Evaluation of the Core Funding Programme for Victims'/Survivors' Groups*. Derry: Clio Evaluation Consortium.

Coll, S. (2006) *Contributing to Well-being. Addressing the Human and Community Consequences of Civil Violence. Standards for Counselling, Listening Ear & Befriending Services*. Enniskillen: Enniskillen Community Victims & Survivors Initiative in Partnership with the Sperrin Lakeland Health and Social Care Trust (February).

Darby, J. and Williamson, A. (1978) *Violence and Social Services in Northern Ireland*. London: Heinemann.

Deloitte & Touche (2001) *Evaluation of Services to Victims and Survivors of the Troubles*. Belfast: Victims Unit, OFMDFM.

Department of Health (2001) *Treatment Choice in Psychological Therapies and Counselling: Evidence Based Clinical Practice Guideline*. London: Department of Health.

Diagnostic and Statistical Manual of Mental Disorders, 4th edn (DSM-IV) (1994) Washington, DC: American Psychological Association.

Dillenburger, K. (1992a) 'The Prevention of Family Break-up Following the Loss of a Child', *Context Magazine. British Association of Family Therapy* 11: 35.

Dillenburger, K. (1992b) *Violent bereavement: Widows in Northern Ireland*. Avebury: Ashgate.

Dillenburger, K., Akhonzada, R. and Fargas, M. (2006) 'Post-trauma: Is Evidence Based Practice a Fantasy?', *International Journal of Behavioral and Consultation Therapy* 2: 95–107.

Dillenburger, K. and Fargas, M. (in press) 'Doing Sensitive Research: Reflection as Development', in P. Maiti (ed.) *Development Studies* (Vol. 3). New Delhi, India: Atlantic Publishers & Distributor.

Dillenburger, K. and Keenan, M. (2005) 'Bereavement: A D.I.S.C. Analysis', *Behavior and Social Issues* 14: 92–112.

Dillenburger, K., Fargas, M. and Akhonzada, R. (2005) 'Victims or Survivors? Debate about Victimhood in Northern Ireland', *International Journal of Humanities* 3: 222–31.

Freedman, J. and Combs, G. (1996) 'Shifting Paradigms: From Systems to Stories', in J. Freedman and G. Combs (eds) *Narrative Therapy: The Social Construction of Preferred Realities*, **[AQ: pp nos?]**. New York: Norton.

Galinsky, M.J. and Schopler, J.H. (1994) 'Negative Experiences in Support Groups', *Social Work in Health Care* 20(1): 77–95.

Harris, T., Brown, G.W. and Robinson, R. (1999) 'Befriending as an Intervention for Chronic Depression among Women in an Inner City: Randomized Controlled Trial', *British Journal of Psychiatry* 174: 219–24.

Harvard Program in Refugee Trauma (HPRT) (2005) 'Psychopharmacology', available online at: [http://www.hprt-cambridge.org/Layer3.asp?page_id=14], accessed 11 October 2005.

Harvey, A.G., Bryant, R.A. and Tarr, N. (2003) 'Cognitive Behavior Therapy for Posttraumatic Stress Disorder', *Clinical Psychology Review* 23: 501–22.

Healey, A. (2004) 'A Different Description of Trauma: A Wider Systemic Perspective – A Personal Insight', *Child Care in Practice* 10: 167–84.

Heslop, P. (2005) 'Good Practice in Befriending Services for People with Learning Difficulties', *British Journal of Learning Disabilities* 33(1): 27–33.
Jarrett, C. (2006) 'What's the Worst Idea on the Mind?', *The Psychologist* 19: 518–19.
Jones, L. (2006) 'On Trauma, Grief, and Memory', keynote address at 3rd International Trauma Research Net Conference: Trauma – Stigma and Distinction, St Moritz, Switzerland, 14–17 September.
Kapur, R. and Campbell, J. (2004) *The Troubled Mind of Northern Ireland*. London: Karnac Books.
Kelly, G. and Smyth, M. (1999) *Report on a Survey of Voluntary Groups Serving the Needs of Those Bereaved and Injured in the Troubles*. Belfast: The Victims Liaison Unit.
LeDoux, L.E. and Gorman, J.M. (2001) 'A Call to Action: Overcoming Anxiety through Active Coping', *American Journal of Psychiatry* 158: 1953–5.
Manktelow, R. (2007) 'The Needs of Victims of the Troubles in Northern Ireland: The Social Work Contribution', *Journal of Social Work* 7(1): 31–50.
Maslow, A. (1954) *Motivation and Personality*. New York: Harper.
Mason, S., Tovey, P. and Long, A.F. (2002) 'Evaluating Complementary Medicine: Methodological Challenges of Randomised Controlled Trials', *British Medical Journal* 325: 832–4.
McConnell, P., Bebbington, P., McClelland, R. and Gillespie, K. (2002) 'Prevalence of Psychiatric Disorder and the Need for Psychiatric Care in Northern Ireland: Population Study in the District of Derry', *British Journal of Psychiatry* 181: 214–19.
McDougall, B. (2006) 'First Interim Report', Northern Ireland Victims Commissioner Office, Belfast (June).
Mohr, W.K. (2004) 'Surfacing the Life Phases of a Mental Health Support Group', *Qualitative Health Research* 14: 61–77.
Moynahan, L. (2001) 'Relatio Ergo Sum – A Suggestive Commentary upon Dillenburger and Keenan', *European Journal of Behavior Analysis* 2: 162–74.
National Centre for PTSD (2005) 'Treatment of PTSD', available online at: [www.ncptsd.va.gov/facts/treatment/fs_treatment.html].
NHS Centre for Reviews and Dissemination (2001) 'Counselling in Primary Care', *Effectiveness Matters* 2.
O'Reilly, D. and Stevenson, M. (2003) 'Mental Health in Northern Ireland: Have 'the Troubles' Made it Worse?', *Journal of Epidemiology Community Health* 57: 488–92.
Osterweis, M., Solomon, E. and Green, M. (eds) (1984) *Bereavement: Reactions, Consequences and Care*. Report by the Committee for the Study of Health Consequences of the Stress of Bereavement, Institute of Medicine, National Academy of Sciences. Washington, DC: National Academy Press.
Parry, G. (2003) 'Evidence-based Psychotherapy: An Overview', in N. Rowland and S. Goss (eds) *Evidence-based Counselling and Psychological Therapies: Research and Applications*, **[AQ: pp nos?]**. London: Routledge.
Pfefferbaum, B. (1997) 'Posttraumatic Stress Disorder in Children: A Review of the Past 10 Years', *Journal of the American Academy of Child & Adolescent Psychiatry* 36: 1503–11.
Rose, S., Bisson, J., Churchill, R. and Wessely, S. (2001) 'Psychological Debriefing for Preventing Post Traumatic Stress Disorder (PTSD)', *Cochrane Database Systematic Review* 3, CD000560.

Shapiro, F. (2001) *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures*, 2nd edn. New York: Guilford Press.
Smyth, M. (2001) 'The "Discovery" and Treatment of Trauma', in B. Hamber, D. Kulle and R. Wilson (eds) *Future Policies for the Past (Report No. 13)*, pp. 57–65. Belfast: Democratic Dialogue.
Sprang, G. (2000) 'Coping Strategies and Traumatic Stress Symptomatology Following the Oklahoma City Bombing', *Social Work and Social Sciences Review* 8: 207–18.
Stroebe, W. and Stroebe, M. (1987) *Bereavement and Health. The Psychological and Physical Consequences of Partner Loss*. Cambridge: Cambridge University Press.
Taggart, A.V., Short, S.D. and Barclay, L. (2000) 'She Has Made Me Feel Human Again': An Evaluation of a Volunteer Home-based Visiting Project for Mothers', *Health and Social Care in the Community* 8(1): 1–8.
Victims Unit (2005) *Services for Victims and Survivors. Consultation on Next Phase of Policy in Relation to Services for Victims and Survivors of the Troubles in Northern Ireland and on the Establishment of a Commissioner for Victims and Survivors*. Belfast: The Victims Unit, OFMDFM (March).
Wessely, S. (2003) *The Trouble with Treating Trauma*. Prague and New York: Project Syndicate (August).

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